The Foot & Ankle Clinic

Tyson Tabora, D.P.M
3319 State Road 7 Suite #113, Wellington, FL 33449
Phone: 561-809-2343 / **Fax**: 888-491-0775
thefootankleclinic@gmail.com
www.tysontabora.com

Patient Name: _____ Date of Birth: _____

Current Address:
_____City_____State____Zip_____

Address Listed with Insurance Company (Leave blank if address is the same):
_____City_____State____Zip_____

Phone: _____ Secondary Phone: _____ Male_____ Female_____

Last 4 of Social Security Number: _____ Employer Name: _____

Email: _____ Would you like to receive e-appointment reminders? **Yes / No**

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy Name & Crossroads: _____ Phone: _____

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Policy Subscriber: _____ Relation: _____ Date of Birth: _____

I give permission to The Foot & Ankle Clinic to release any information requested by my insurance company. I also give permission for Dr. Tyson Tabora to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to The Foot & Ankle Clinic for services provided.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____Date: _____

How did you hear about our office? (Please do not leave blank): _____

History and Physical

Please be sure to answer **ALL** the questions.

What is the chief complaint for which you came to be treated?

_____ Height: _____ Weight:_____

Date pain started: _____ Indicate Body Part: **Right / Left** **Foot/Ankle** **Pain Level (1-10): _____**

Describe accident / incident (If applicable):

_____

Have you seen a Podiatrist before? **Yes / No** If Yes, please tell us the name of the doctor and the history of foot/ankle problems you were treated for (Include foot, ankle and Leg):

_____

Last Visit_____ Any other foot or ankle problems? _____

Do you drink alcohol? **Yes / No** Frequency: _____

Do you smoke? **Yes / No** Frequency: _____ Former Smoker **Yes/ No** Date Quit: _____

Shoe Size: _____ Width: _____

Allergies (Please circle all that apply):

Adhesive Tape	Aspirin	Codeine	Demerol	Iodine	Local Anesthetics
Novocaine	Penicillin	Sulfa Drugs	Ibuprofen	Other	No Allergies

Other: _____

Family Medical History (Please circle all that apply):

Ankle Pain	Bunions	Calluses	Restless Leg Syndrome	Heel Spurs	Other Spurs
Athlete's Foot	Numbness Foot or Leg	Ingrown Nails	Heel Pain	Flat Foot	Leg Cramps
Foot Cramps	Tired Feet	Plantar Wart	Swelling of Ankles and or Feet	Corns	Foot Pain

Medical History (Please circle all that apply):

Stroke	Diabetic	High Cholesterol	Stomach Ulcers	Heart Disease	Phlebitis	Respiratory Disease	Kidney Problems	Glaucoma	AIDS/ HIV
Anemia	Circulatory Problems	High Blood Pressure	Artificial Valves	Implanted Device	Artificial Joints	Blood Clots/DVT	Gout	Anxiety	Cancer
Hepatitis	Epilepsy/Seizures	Low Blood Pressure	Liver Disease	Bleeding Disorder	Arthritis	Hypothyroidism	Varicose Veins	Depression	Other

Other: _____

Medications (Please write **legibly** or provide us with a typed copy):

Name of Medication	Strength	Dose/Frequency

Release of Medical Records and Information

This office is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentiality. If you have any concern, please feel free to discuss them with our office manager.

Medical Records Information Release

I understand by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the social security administration and the health care financial administration, its intermediaries carry and information needed for this or any related claim.

_____**Initials**

Medical Records Release to Hospitals/Physicians

I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentiality.

_____**Initials**

Medical Records Release to Family

I authorize Dr. Tabora to release information pertaining to my illness and/or treatment to_____. I authorize Dr. Tabora to leave medical information on my answering machine. I also authorize information to given to my spouse.

_____**Initials**

Medical Records

One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for any additional copies. There will be a charge of $1.00 per page. Please allow 10 days for copying all medical records.

_____**Initials**

Patient Rights to Confidentiality

I understand that The Foot & Ankle Clinic office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility: however, this request must be in writing. I understand that by law this office may only release medical records that were generated by The Foot & Ankle Clinic. We cannot release medical records from other physicians, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

Patient Name_____Signature_____

Financial Policy

Payment of Benefits to the Physician/ Provider

I, the undersigned, understand that Dr. Tyson Tabora has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment is paid to Dr. Tyson Tabora. I understand that I am financially responsible for any changes that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance.

Signature: _____ Date: _____

Method of Payment

Payment is Required at the time service is rendered. Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay or coinsurance amount at the time of your visit. Please make sure your insurance is active and remember to notify our office of any changes. If your insurance is inactive at the time service is rendered, you will be responsible for the charges due.

In the event your check is returned for any reason, your account will be charged $25.00. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the amount may be referred to a collection agency or attorney.

For your convenience, we accept MasterCard, Visa, American Express, Discover, and Care Credit as well as cash and checks. Checks are preferred. We accept card payments as a courtesy. If you need to pay a bill over the phone, we are happy to provide that service for you; however, please be aware that there is a convenience fee of $5.00 for any phone payment or payment that requires manual entry for services or purchases under $100.00. For any amount over $100.00, the service fee will change. The fees are subject to change based on the fees from our vendors.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you should have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my right and responsibilities.

Signature_____Date_____

The Foot & Ankle Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ D.O.B: _____

With this form, I, _____, hereby voluntarily authorize that my medical records be
(Name of Patient)
disclosed and sent to The Foot & Ankle Clinic to be reviewed by Dr. Tyson Tabora.

Information Requested:

_____

_____

The information is to be provided to:

The Foot & Ankle Clinic
Tyson Tabora, D.P.M.
3319 SR 7 #113, Wellington, FL 33449
Phone: 561-809-2343
Fax: 888-491-0775

***Please fax records to 888-491-0775**

- I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying The Foot and Ankle Clinic in writing.
- I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
- I may inspect or copy any information used or disclosed under this agreement.
- I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

Under HIPAA with patients' written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with patient's written request, records must be provided within 15 days of a request.

HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.

The Foot & Ankle Clinic

Consent to Photograph Form

The Foot & Ankle Clinic actively participates in events and social media. We welcome you to be a part of our social media outreach! Share, like, comment and subscribe!

I _____ hereby authorize and give consent to photograph / film and publish for educational purposes, the practice website and or social media purposes including the following:

- Educational purposes
- Practice website
- Facebook
- Instagram
- Other social media

_____ _____ _____

Name Date of Birth Date

We do not use names on any of our sites, but if you do not wish to participate in any of the above, please indicate below:

_____

_____

Signature

_____

Witness Signature